# TerraNova Homes & Care Limited - Monte Vista Residential Care

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** TerraNova Homes & Care Limited

**Premises audited:** Monte Vista Residential Care

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 26 October 2017 End date: 26 October 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 30

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Monte Vista Residential Care is part of TerraNova homes and Care Ltd. The service provides rest home and hospital(medical and geriatric) level care for up to 41 residents. On the day of audit there were 30 residents.

This surveillance audit was conducted against a subset of the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, staff and management.

The organisation has a clearly defined scope, direction and goals documented in the service marketing literature and the 2017/2018 business plan, and quality and risk plan. The management team are supported by executive management during weekly teleconferences and four six-weekly face-to-face meetings.

The facility manager of Monte Vista Residential Care is a registered nurse (RN) who has extensive experience as a manager in the aged care sector. She has been in the facility manager role for the past five years. She was absent on the day of audit. The facility manager is supported by a clinical coordinator, who has four years’ experience as a clinical manager in the aged care sector and has been in the position for one month.

There was one corrective action required from the previous audit around quality review of restraint. This had been addressed. This audit identified further improvements around implementation of the training programme, self-medication monitoring, care plan interventions and use of enablers.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

A policy on open disclosure is in place. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Quality and risk management processes continue to be well maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service and organisational goals are embedded into practice. Key components of the quality management system link to a number of meetings. An annual resident/relative satisfaction survey is completed and there are bi-monthly resident meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. A robust health and safety programme is in place, which includes hazard management, incident and accident reporting and health and safety processes. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. An annual education planner is rolled out annually by the organisation. Registered nursing cover is provided 24-hours a day, 7 days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The registered nurses are responsible for the provision of care and documentation of each stage of service delivery. All resident files reviewed evidenced that assessments and care plans had been completed and evaluated within the required timeframes. InterRAI assessments are completed within required timeframes or when there is a change in health condition. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. The activities coordinator implements the activity programme and it meets the individual needs, preferences and abilities of the residents. Community links are maintained. There are regular entertainers, outings and celebrations. Staff who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner. Residents' food preferences and dietary requirements are identified at admission. All meals are cooked on-site.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building holds a current warrant of fitness.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The use of an enabler was identified as voluntary, but consent process was not completed appropriately.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

Infection surveillance programme is implemented, and it is linked to the quality and risk programme. There is an organisation-wide infection control steering group that meets quarterly. An external contractor benchmarks surveillance data with other facilities within the group.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 13 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 3 | 1 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and relatives on entry to the service. The facility manager maintains a record of all complaints, both verbal and written, by using a complaint’s register. Complaints are documented on the organisation’s electronic system (People Point). These are also monitored by head office. Discussions with residents and relatives confirmed they were provided with information on complaints. Complaints forms are in a visible location at the entrance to the facility. Two complaints received since the last audit were reviewed, with evidence of appropriate follow-up and actions taken. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Standard operating procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is an open disclosure policy. Accident/incident forms and electronic records of incidents (on People Point) have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twelve accident/incident forms reviewed for October 2017 identified that family were kept informed. Five residents (two hospital and three rest home) and five family members (four hospital and one rest home) interviewed, confirmed on interview that the staff and management are approachable and available. Staff were observed communicating effectively with residents. The information pack is available in large print and advised that this can be read to residents. An interpreter service is available and accessible if required. Families and staff are utilised in the first instance.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Monte Vista Residential Care provides rest home and hospital level care for up to 41 residents. On the day of audit, there were 30 residents in total, 15 residents requiring rest home level care, including one younger persons with disabilities (YPD) resident and 15 residents requiring hospital level care, including one resident on respite (ACC funded contract). There are 40 rooms designated for dual use as either rest home or hospital. The service is one of three facilities owned and operated by TerraNova Homes and Care Ltd. The company has established systems, policies and procedures for providing a consistent approach to service delivery in all their homes. The organisation has a clearly defined scope, direction and goals documented in the service marketing literature and the 2017/2018 business plan and quality and risk plan.The facility manager of Monte Vista Residential Care is a registered nurse (RN) who has extensive experience as a manager in the aged care sector. She has been in the facility manager role for the past five years. The facility manager is supported by a clinical coordinator, who has been in the position for one month. She has four years’ experience as a clinical manager at another facility. The facility manager was absent on the day of the audit. The management team are supported by executive management during weekly teleconferences and four six-weekly face-to-face meetings. Information about operations including clinical data, occupancy, staffing and finances is reported via a balanced scorecard to head office each month. This provides targets for performance. The facility manager has completed more than eight hours of training in the last year relating to the management of a hospital, by attending regular professional development and industry conferences. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | TerraNova has robust quality and risk management systems implemented across its facilities. A robust risk management system is in place. All incidents are reported on ‘People Point’ and reviewed by the clinical coordinator and facility manager on a daily basis. Incidents are also able to be reviewed in detail by the chief executive officer (CEO) and Clinical Quality & Risk (CQ&R) advisor on ‘People Point’. The online ‘ZAP reporting’ system is being implemented which pulls data/clinical indicators from People Point (electronic system). This gives a more thorough analysis and is managed by the TerraNova CQ&R advisor who supports the managers at Monte Vista to further analyse the data and introduce corrective actions where needed. Interviews with the staff reflect their understanding of the quality and risk management systems. TerraNova’s policies, procedures and relevant forms are available both in hard copy and online under ‘Share Point’ (intranet). Updated documents are released/supplied to the facility. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): resident falls, infection rates, complaints received, restraint use, pressure injuries, wounds and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented when service shortfalls are identified. Quality and risk data, including trends in data and benchmarked results are discussed in the monthly staff meetings.Resident meetings occur bi-monthly and an annual resident survey is completed. The last resident satisfaction survey in April 2017 identified an 81% overall score. There were some improvements made as a result of the survey including (but not limited to) increasing the range of activities. Three steering groups at an organisational level have been implemented including a restraint, health and safety, and infection control group. A representative from Monte Vista attends each of the organisational steering groups. A health and safety system is in place. Health and safety is an agenda item of the staff meeting. Hazard identification forms (recorded in People point) and a hazard register are in place. There are organisational three-monthly health and safety meetings, with a focus on reducing hazards and promoting safe work habits amongst employees. The health and safety representative reports to the staff meeting any health and safety issues and hazards. Falls prevention strategies are in place. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Twelve accident/incident forms were reviewed and electronic records of incidents (on People Point) identify follow-up by a RN. Each event involving a resident reflected a clinical and RN assessment. Incidents are benchmarked and analysed for trends. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. The managers were aware of their requirement to notify relevant authorities in relation to essential notifications. There had been no requirement for any section 31 notifications since the last audit. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (one clinical coordinator, one RN, two caregivers and one activities coordinator) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates is maintained.The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. New staff are buddied for a period of time and during this period they do not carry a clinical load. An induction booklet for caregivers was rolled out across the organisation in 2016. The booklet aligns with careerforce unit standards -Health and Wellbeing level two and they have 90 days to complete. On completion of this orientation, the staff member has effectively attained their first national certificates. From this, they are then able to continue with core competencies level-3 unit standards. An annual education planner is rolled out annually by the organisation. There is an annual education planner in place for 2017, however, the planner has not been fully implemented. A competency programme is in place with different requirements according to work type. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). Competencies include (but not limited to): fire safety, medication, manual handling, controlled drug checking, use of restraint, standard precautions and wound care.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The facility manager works full-time from Monday to Friday and the clinical coordinator works 4.5 days a week. The facility manager and clinical coordinator share the on-call out-of-hours duties. Adequate RN cover is provided 24 hours a day, seven days a week. There is one RN on duty on the morning shift and on the afternoon shift, and one on the night shift across the facility. The RNs are supported by an adequate number of caregivers. There are four caregivers on the morning shift, three caregivers on the afternoon shift and one caregiver on the night shift. The organisation uses ‘time target’ for monitoring staff hours and as a communication tool. Staff interviewed, advised that there are sufficient staff on duty at all times. Interviews with residents and relatives confirm that there are sufficient staff on duty. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored in locked medicine trolleys and in a locked room. Medications that require refrigeration are stored in a separate and locked fridge. A sample of 12 medication charts were reviewed (six rest home and six hospital). Medication charts are in hard copy in the medication folder. Prescription and administration records are legible, signed, dated and written in ink. The GPs review residents three monthly, as evidenced on the medication charts reviewed. Allergies and sensitivities were documented. Medication errors were reported via the incident and accident reporting system and these were investigated and communicated to all staff to prevent recurrence. Allergies and resident photographs were evident in all 12 medication charts reviewed and all medication orders recorded indication for use for ‘as required’ medication (PRN). As required (PRN) medications are administered in consultation with the resident and according to their individual needs. Two files with PRN administration of medication were reviewed. Both medication charts viewed confirmed the use of PRN medication and the residents interviewed confirmed they were consulted.Registered nurses and medicine competent caregivers administer medications. Staff who administer medication have been assessed as competent. Registered nurses are trained by the hospice in the use of syringe drivers. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy.There are policies around self-administration of medicine and self-medication is facilitated by the RNs but recording and monitoring of self-medication administration do not occur.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The service employs two cooks who work seven days between them. There are also kitchen assistants who support the cook in food preparation and serving dinner meals. All staff have current food safety certificates. There is a well-equipped kitchen and all meals are cooked on-site. The resident’s nutritional profile identifies dietary requirements, allergies and likes and dislikes. Changes to residents’ dietary needs are communicated to the kitchen. The temperatures of refrigerators, freezers and cooked foods are routinely monitored and recorded. These were all within safe limits. There are special equipment and utensils available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. There is a four-week rotating menu with summer and winter variations. The menu has been reviewed by a dietitian in March 2017. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.The kitchen is able to meet the needs of residents who require special diets and the cooks work closely with the RN. There are self-serve tea and coffee facilities alongside a water filter that residents and families are able to access easily and at any time.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Services are delivered in a respectful manner and staff were considerate of residents' needs as evidenced on the day of audit. Six files were reviewed. In four files, all parts of the care plan interventions reflected the resident’s current needs and appropriately guide staff in care delivery, but two files did not include interventions associated with risks of anticoagulant therapy and had lack of information related to culture, religion and spirituality preferences of individual residents. Monitoring charts sighted included (but were not limited to), vital signs, blood glucose, pain, food and fluid, turning/repositioning charts, restraint and behaviour monitoring. Review of these records showed that turning charts were not always recorded as planned.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by two activities coordinators. One is an internationally trained RN with interest in diversional therapy. He has undertaken this role as maternity leave cover for 12 months. The second activities coordinator works two days a week and has experience in this field. The activities programme is developed monthly, and a weekly programme was displayed in common areas and a copy is given to residents individually. On entry to the service, an initial assessment obtaining a complete history of past and present interests, career, family and culture is completed. Resident files reviewed identified that the individual activity plan was reviewed at least six-monthly. Church groups visit regularly. There are weekly van outings and entertainment. Monthly lunch and picnic outings are part of the activities programme. Community connections are maintained, and several groups visit the facility regularly. There are four volunteers who support group and individual activities. All residents are encouraged to attend community events groups. There is easy access to outside areas that enables residents to come and go safely. The YPD resident likes to join in activities and goes to community events. Daily activities attendance sheets were maintained for each resident in people point, and review of the activities programme includes achievement of individual goals. On the day of audit, residents were observed being actively involved with a variety of activities. Resident and family member interviews confirmed that activities offered are age appropriate and meet the needs and choices of residents. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plan evaluations reviewed were documented and identified current progress of the resident. Short-term care plans reviewed had been evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Short-term care plans were sighted for wound care, pain, infections, and behaviour management. Activities plans are evaluated six-monthly at the same time as the long-term care plans. Staff stated that family members are informed of any changes to the care plan and this was evidenced in the progress notes. The caregivers interviewed were knowledgeable around residents’ acute care needs and they reported that they have time to read care plans and acute changes discussed at handover. Family interviews confirmed consultation with families if changes are required in current care plans.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness which expires on 11 May 2018. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | An infection surveillance programme is implemented, and it is linked to the quality and risk management programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed (infection control (IC) wizard on People Point). Monthly infection data is collected for all infections based on signs and symptoms of infection. An infection analysis summary is auto-populated. The IC coordinator has utilised these summaries to identify trends and reduce infections. Graphs, corrective actions and outcomes are shared with staff through meetings. There is an organisation IC steering group that meets two monthly with the last meeting having occurred in September 2017. Short-term care plans are used. One gastro outbreak in December 2016 was managed appropriately and effectively. An external contractor benchmarks surveillance data for the group with other providers in the sector. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | PA Low | The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The use of the enabler was identified as voluntary, but consent process was not completed appropriately. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings and restraint steering meetings at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers. The service is restraint-free with five residents using enablers in the form of bed rails. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint policy and quality review process take into account all aspects as listed in this criterion. Since the previous audit, an organisation-wide restraint steering group had been established. This group meets two monthly and the last meeting was held in September 2017. This group supports the restraint coordinator and creates an organisation-wide learning platform. Meeting minutes showed evidence of organisational intent to reduce restraint use. Therefore, this previous finding is closed. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | An annual education planner is rolled out annually by the organisation. There is an annual education planner in place for 2017, however, the planner has not been fully implemented. Nineteen out of twenty-seven education sessions have not been completed up to the end of October 2017. Corrective actions are in place to complete the education sessions not completed.  | Nineteen out of twenty-seven education sessions for 2017 have not been completed. Education sessions that have not been completed are for the following topics; code of rights, abuse/neglect, privacy/dignity, care planning, infection control, oral hygiene, challenging behaviours, medication management, nutrition/hydration, restraint, catheter care, falls prevention, chemical safety, complaints/open disclosure, cultural awareness, syringe drivers, spirituality/counselling and sexuality/intimacy.  | Ensure that the annual education planner is fully implemented, and education is provided to cover all contractual and legal requirements. 90 days |
| Criterion 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | There were four residents self-administering medicines. These included inhalers and anticoagulant medication (warfarin and aspirin). Competency assessments to self-administer medications were in place and reviewed three monthly by the GP but recording and monitoring of self-medication administration was not documented. | Four residents were self-administering their own medication. Recording and monitoring of self-medication administration was not documented.  | Ensure that monitoring of self-medication occurs.30 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | A written record of each resident’s progress is documented. Residents’ changes in condition are followed-up by an RN as evidenced in residents' progress notes. Family members interviewed stated that they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. There was documented evidence of relative contact for any changes to a resident’s health status. In four files, all parts of the care plan interventions reflected the resident’s current needs, and appropriately guide staff in care delivery but two files did not include interventions associated with risks of anticoagulant therapy and had lack of information related to culture, religion and spirituality preferences of individual residents. The GP reported that coordination of care is very good and medical issues are reported promptly and required follow-ups are completed. When a resident’s condition and/or care plan interventions change, the RN initiates a GP visit, and when required the clinical coordinator facilitates a referral to an external specialist. Continence products are available and resident files include continence assessment, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed, and this could be described by the RNs interviewed. Caregivers and RNs interviewed stated that there is adequate continence and wound care supplies.Wound assessment, wound management and evaluation forms were in place. There were eight wounds being treated on the day of audit. This included one stage-2 pressure injury, two chronic skin conditions and five skin tears. Appropriate care of all wounds was documented and provided. Access to specialist advice and support is available. Monitoring charts sighted included (but were not limited to), vital signs, blood glucose, pain, food and fluid, turning/repositioning charts, restraint and behaviour monitoring. Review of these records showed that turning charts were not always recorded as planned. Registered nurses and caregivers interviewed demonstrated a good knowledge of individual resident’s specific care that was reflected in the resident’s care plan. Staff were considerate of residents' needs as evidenced on the day of audit. Resident and family interviews showed satisfaction with care provided.  | (i) In two files (rest home), resident’s cultural, religious and spiritual parts of the care plan did not include any information to guide staff. The care plan interventions part of the care plan had only written “assist and support with preferences”. These preferences were not identified. This information was also not available in the activities part of the care plan. (ii) Turning charts related to pressure injury prevention were not always completed during day time. Gaps between recordings of re-positioning were four to five hours in some cases, although it was required to be checked two-hourly. (iii) Two residents were using anticoagulant therapy, one was on warfarin and another was on warfarin and aspirin. Both files did not include risks relating to anticoagulant therapy.  | (i) Ensure that resident’s cultural, religious and spiritual preferences are documented in the care plans. (ii) Ensure that turning charts are completed as identified timeframes. (iii) Ensure that care plan interventions include risks related to use of anticoagulant medication. 90 days |
| Criterion 2.1.1.4The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings and restraint steering meetings at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers. The service is restraint-free with five residents using enablers in the form of bed rails but consent process for use of enablers was not completed appropriately | There were five residents using bed rails as an enabler. Two were signed by the next of kin. One was signed by the EPOA, but the EPOA had not yet been activated. The clinical coordinator who was recently appointed to the position was aware of this issue but the process has not yet been rectified | Ensure that enabler use is voluntary, and the consent process is completed by the resident or person with EPOA90 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.